Soft Shepherd or Almighty Pastor?

Power and Pastoral Care

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The Meaning of Informed Consent in Pastoral Counseling

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THIS PAPER INVESTIGATES THE meaning of informed consent in pastoral counseling. Its perspective is determined by three elements. The object of our investigation is the encounter and conversation between a pastor and a patient. The context is the field of health care in which pastoral counseling happens. And the approach of our study is by way of an ethical analysis and evaluation.

We begin our investigation with a description of the asymmetry and power imbalance in the pastoral relationship and with an ethical analysis of this power imbalance. Then we explore the concept of informed consent through the literature of medical ethics, patients' rights, and pastoral ethics and make some feasible applications. Thereafter, we affirm that not only the consent of the patient, but also the intention of the pastor is essential to deal with power in an ethical manner. By way of conclusion we formulate ten statements.

ASYMMETRY AND POWER IMBALANCE

Pastoral counseling is the encounter and conversation between a pastor and a patient. The counseling is grounded in the relationship between these two persons. One of the most important characteristics of this relationship is its asymmetry and power imbalance.[1]

Asymmetry

The pastoral relationship may well be a mutual one, in the sense that both partners are involved and communicate with each other. The relationship can also be considered as one of equals, in the sense that both partners enjoy the same dignity as human persons. However, they are unequal in terms of their relative position within the pastoral relationship: the one is the pastor and the other is the patient. Asymmetry characterizes the relationship in that the partners have an unequal position.

We can clarify this unequal position by referring to three characteristics of the pastor's identity, more precisely the ecclesiastical, the professional, and the personal character of his or her identity.[2] To begin with, the pastor holds an official position, a ministry in the church. This gives the pastor the authority to act and to speak on behalf of the community. In some cases, this authority may originate from an even more exalted source, since the patient may regard the pastor as being the direct representative of God, which can lead to the ascribing of all kinds of "superhuman" qualities to the pastor. Moreover, the pastor not only holds a ministerial position, but also has a professional status. The pastor is a theological and spiritual expert as well as a professional counselor in matters of meaning and faith. This implies much knowledge and skill in these matters. The pastor also belongs to the group of care providers who collaborate in teams and networks and who share information, even potentially confidential information. Finally, the pastor is a human person, a man or a woman who has grown toward a personal religious conviction and spirituality, in dialogue with the faith tradition and the contemporary culture. Therefore, he or she can be

1. Cf. Doehring, *Taking Care*, 74–103; Gula, *Just Ministry*, 117–55; Lebacqz, *Professional Ethics*, 109–23; Lebacqz and Diskrill, *Ethics and Spiritual Care*, 72–77; Neuger, "Power and Difference," 65–85; Schenderling, *Beroepsethiek voor pastores*, 195–201; Trull and Carter, *Ministerial Ethics*, 90–97.

2. Heitink, *Practical Theology*, 310–24.

an example or a witness for many people who attach great importance to spirituality and faith.

The patient who seeks pastoral counseling is placing great reliance on the ecclesiastical, professional, and personal position of the pastor. At the same time, the patient is in a vulnerable and dependent position.[3] The patient is vulnerable because he or she has a question, a need, or a problem that is difficult to solve on his or her own. Or the patient would like to share an intimate life experience, of which he or she is perhaps ashamed. The patient is vulnerable because he or she will need to reveal a personal matter and disclose sensitive information. This makes the patient dependent on the support of the pastor and on confidence in the pastor.

Power Imbalance

This unequal position creates an inequality or imbalance in the relationship. This imbalance is inevitably a power imbalance. Power means the ability to influence or control other people. Power can be very evident, as in the physical or psychological abuse of a patient. It can also be very subtle in the use of words, in the non-verbal attitude, or by the desire to be available or to help the patient, without really involving him or her. Obviously, the pastor has more power. In particular situations, the patient can also exercise limited power over the pastor and the pastor can feel very powerless and helpless. Despite this possibility, the power imbalance is usually to the advantage of the pastor because of the structure of their relationship.

Indeed, the unequal position and the power imbalance are structural facts. They are inescapable facts in the pastoral relationship as well as in any other caring and helping relationship. Unequal position and power imbalance belong to the inherent structure of any professional relationship. They anticipate the manner in which pastor and patient relate to each other. They are structural facts and not immediately an ethical matter.

Premoral Evil and Moral Evil

From an ethical point of view, it is helpful to make a distinction between the "premoral" dimension on the one hand and the "moral" dimension on

3. van Heyst, "Professional Loving Care," 199–217.

the other hand.[4] This distinction refers to the ambiguity of the human action. All human actions contain some features that have the potentiality of improving the well-being and quality of life of human beings and some features that potentially threaten it. According to Gula, these features are premoral goods "to the extent that these features enhance the potential for human goodness and growth," and they are premoral evils "to the extent that these features frustrate the full potential for promoting the well-being for persons and their social relations."[5]

We consider the unequal position and the power imbalance as premoral evils. On the one hand, they are evaluated as "evil" because they do not improve the potential for the well-being of human persons. The reason is that on a philosophical and anthropological level all human beings are considered as fundamentally equal. The *Universal Declaration of Human Rights* affirms that "all human beings are born free and equal in dignity and rights."[6] And from a theological perspective, all human beings are created in the "image of God."[7] Unequal position and power imbalance hence have the potentiality for threatening the fundamental equality of human persons. On the other hand, unequal position and power imbalance are qualified as "premoral" because they are inevitable features in human actions. These facts are not immoral or unethical, but premoral or pre-ethical. Their potentiality becomes reality, and thus moral or ethical, through human actions.

This insight has important consequences for the pastor's moral behavior. The moral or ethical character of the pastor's action depends on how he or she deals with the premoral evil of unequal position and power imbalance.[8] The pastor's intention or purpose should not be to engage in the pastoral relationship for his or her own benefit, but for the benefit of the patient. This implies firstly that the pastor should deal with the power imbalance in a way that does not harm the patient. Here the principle of non-maleficence is at stake. This secondly implies that the pastor should

4. Gula, *Reason Informed by Faith*, 269–70; Janssens, "Ontic Evil and Moral Evil," 133–56; Janssens, "Ontic Good and Evil," 70–82.

5. Gula, *Reason Informed by Faith*, 269.

6. General Assembly of the United Nations, "Universal Declaration of Human Rights," art. 1.

7. Genesis 1:26–27. Cf. Gula, *Reason Informed by Faith*, 64–66.

8. See below on the "sources of morality."

handle power in a way that is to the advantage of, or helps, the patient. Here we refer to the concept of empowerment.

Empowerment

Empowerment is an important concept in the social sciences and in psychosocial care.[9] We understand empowerment in an ethical way as enhancing responsibility, giving another person more power and strength so that he or she is better able to assume responsibility in his or her life. Hence, the pastor's intention or purpose should be to empower the patient, to make him or her more powerful. The patient is then better able to assume his or her own responsibilities. At the same time, the pastor can redress the imbalance of power within the pastoral relationship. Empowerment is an important characteristic of the pastoral relationship.

Consequently, we define pastoral counseling as an empowering companionship between a pastor and a patient.[10] In the relationship, the patient searches for meaning and/or faith in life, while the pastor, inspired by the Christian tradition and community, accompanies him or her. Empowerment expresses the purpose of pastoral counseling: the pastor empowers the patient in his or her own quest for meaning and/or faith in life. In other words, the purpose of pastoral counseling is to encourage and strengthen the patient so that he or she is able to understand meaning and/or faith in life more clearly and to experience them more deeply.

An important consequence of these reflections on power is that the person who has the greater power in the relationship also bears the greater responsibility toward that relationship.[11] Because of the fact of the unequal position, the pastor has the greatest power and the greatest responsibility. This imposes a twofold responsibility on the pastor: the responsibility not to abuse the power, or to harm the patient, and the responsibility to empower the patient in his or her quest for meaning and/or faith in life. In order to give substance to the idea of empowerment and to redress the imbalance of power in the pastoral relationship, we can refer to the concept of informed consent. Asking for informed consent can be considered as the pre-eminent means of respecting the patient's autonomy.

9. Cf. Van Regenmoortel, *Empowerment en participatie*, 9–19.

10. Liégeois, "Pastoral counselling in care services," 129.

11. Gula, *Just Ministry*, 133.

INFORMED CONSENT

The main goal of this paper is to explore the possibilities and limits of informed consent as a means of adjusting the imbalance of power. Therefore, we investigate this concept through several sources in literature and examine the meaning of informed consent in pastoral counseling.

The Principle of Informed Consent

In their book *Principles of Biomedical Ethics*, Beauchamp and Childress have developed an authoritative view of informed consent.[12] In their opinion, the meaning and justification of informed consent is to be found in the principle of respect for autonomy. They remark that initially, from the 1950s on, informed consent was considered as a way to protect the patient from potential harm. But since the 1970s, the primary purpose of informed consent has been to improve the patient's autonomous choice. In this latter period, they observe in the 1990s a shift of emphasis from the care provider's obligation to disclose information, to the patient's quality of understanding and consenting.[13]

Beauchamp and Childress are very principled. They distinguish seven elements in informed consent. First, they propose two "threshold elements" or preconditions, namely (1) the patient's "competence" to understand and to make a decision and (2) the "voluntariness" in deciding. They subsequently make a distinction between three elements of information, specifically (3) the care provider's "disclosure" of material information, (4) the "recommendation" of a certain intervention, and (5) the patient's "understanding" of the former elements of disclosure and recommendation. Finally, they consider two elements of consent, namely (6) the patient's "decision" in favor of a certain intervention and (7) the "authorization" of that chosen intervention.[14] Based on these elements, informed consent can be conceptualized as the voluntary decision and authorization of a competent patient in favor of a certain intervention, on the basis of the understanding of the information about and the recommendation concerning that intervention.

12. Beauchamp and Childress, *Principles of Biomedical Ethics*, 117–40.
13. Ibid., 117–18. Cf. Faden et al., *A History and Theory of Informed Consent*, 114–50.
14. Beauchamp and Childress, *Principles of Biomedical Ethics*, 117–35.

Although Beauchamp and Childress highlight and prefer informed consent, they also give some attention to other forms of consent. They propose surrogate decision-making in order to protect patients who are not able to give consent, based on advance directives, or made by the family, the care providers, an ethics committee or the judicial system.[15] They also briefly mention other forms of consent, without elaborating them: expressed, tacit, implicit or implied, and presumed consent.[16]

Planned and Unplanned Pastoral Counseling

It is not easy to apply the well-defined concept of informed consent to pastoral counseling. In some situations, pastoral counseling is a planned activity with a series of sessions. The pastor and the patient can then talk about the nature and the purpose of pastoral counseling, and they can make appointments to meet. Information and consent are part of the process of planning the counseling sessions.

But in most situations, pastoral counseling is not planned this way. It has an accidental or occasional character. Pastor and patient meet by chance and in an unintentional way. They engage in a conversation, and no specific attention is given to providing information and giving consent. It is very artificial, and the request of an express informed consent for the encounter may be counter-productive. Nevertheless, the spontaneous conversation can be the starting point for further planned conversations or appointments.

Although informed consent could be very important in pastoral counseling, it is not easy in practice: perhaps it is achievable for planned pastoral counseling, but it will seldom be practicable for unplanned counseling. Therefore, we continue our exploration of literature on patients' rights in order to find concepts of informed consent that are more applicable to pastoral counseling.

15. Ibid., 185–90.

16. Ibid., 107–8.

Patients' Right to Informed Consent

An authoritative document concerning patients' rights is *The Convention on Human Rights and Biomedicine* of the Council of Europe.[17] This is a legal and political document with a global relevance in health care throughout the European Union.

The Convention affirms the already well-established rule of informed consent in medical law and medical ethics. It states that "an intervention in the health field may only be carried out after the person concerned has given free and informed consent to it."[18] The Explanatory Report clarifies that the word intervention is to be understood in the "widest sense" so that "it covers all medical acts."[19] According to the Convention, consent has two important characteristics, namely being informed and being freely given. Informed consent means that consent is given on the basis of objective information. The care providers give "appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks."[20] The information should be given beforehand, and thus precede the intervention. The information should also be appropriate, this means "sufficiently clear and suitably worded" for the patient.[21] Free consent means that no pressure is applied from any person. Freedom implies that the patient "may freely withdraw consent at any time."[22]

17. Council of Europe, "Convention on Human Rights and Biomedicine." The European Committee of Ministers adopted the Convention on 19 November 1996 and its Explanatory Report on 17 December 1996. The Convention was opened for signature on 4 April 1997. Australia, Canada, the Holy See, Japan and the United States of America also took part in the Convention's preparation and are obligated to take a stand on it. The Convention had a determining influence on many national acts on patients' rights, such as the Belgian act of 22 August 2002. Cf. Liégeois et al. "An Ethics of Deliberation," 73–75.

18. Council of Europe, "Convention," art. 5.

19. Council of Europe, "Explanatory Report," nr. 34.

20. Council of Europe, "Convention," art. 5.

21. Council of Europe, "Explanatory Report," nr. 36.

22. Council of Europe, "Convention," art. 5.

Various Forms of Consent

The Explanatory Report develops the idea that consent may take various forms: express or implied.[23] This explanation is very important for the purpose of pastoral counseling. The Report states that "express consent may be either verbal or written," and that the form "will largely depend on the nature of the intervention."[24] The Report affirms that "it is agreed that express consent would be inappropriate as regards many routine medical acts," and that "the consent is therefore often implicit, as long as the person concerned is sufficiently informed."[25] For the inverse situations, the Report explains that "in some cases, however, for example invasive diagnostic acts or treatments, express consent may be required," and that "the patient's express, specific consent must be obtained for participation in research or removal of body parts for transplantation purposes."[26]

Implicit Consent for Pastoral Counseling

The Explanatory Report makes clear that express informed consent is probably not necessary, and that implicit consent is likely to be sufficient for pastoral counseling. There are several arguments. First, the Report asserts that informed consent is necessary for "medical acts."[27] Is pastoral counseling a medical act? Certainly, pastoral counseling is an act in the context of health care and may have beneficial effects on the patient's health. But in our opinion, pastoral counseling is not a medical act, because otherwise we confuse the specific contribution of the disciplines in health care. The disciplines should be distinguished and recognized in their identity and specificity, in the knowledge that they are interconnected and complementary. Consequently, care providers should work in an interdisciplinary way, but may not mix the disciplines.

Secondly, the Explanatory Report asserts that express consent may be required for "invasive diagnostic acts or treatments" and should be obtained for "participation in research."[28] It is clear that pastoral counseling does

23. Council of Europe, "Explanatory Report," nr. 37.
24. Ibid.
25. Ibid.
26. Ibid.
27. Cf. above on the explanation of the word intervention, and note 19.
28. Cf. above on express consent, and note 24.

not belong to these types of interventions. On the other hand, the Report supports the possibility of implied consent, especially for routine medical acts. This possibility may sometimes be applicable to pastoral counseling. Nevertheless, for non-invasive interventions the consent might be implicit "as long as the person concerned is sufficiently informed."[29]

This is an important statement in respect to pastoral counseling. When express consent is not achievable, in either written or verbal form, an implicit consent is practicable for pastoral counseling. But there is an important condition: the patient should be sufficiently informed.

Protection of Patients Not Able to Consent

The Convention continues with some articles on the protection of patients who are not able to give consent for a certain intervention. An adult may be considered unable to consent "because of mental disability, a disease or similar reasons."[30] These reasons refer to situations in which the patient is "unable to formulate his or her wishes or to communicate them."[31] The Convention then establishes a first condition concerning the protection of the patient: the intervention must be "for his or her direct benefit."[32] The second condition concerns the surrogate consent, for a minor as well as for an adult, and implies "the authorization of his or her representative or an authority or a person or body provided by law."[33]

Nevertheless, the patient is not ruled out. For a minor, his or her opinion "shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity."[34] For an adult, he or she "shall as far as possible take part in the authorization procedure."[35] This means that, for patients, it will be necessary "to explain to them the significance and circumstances of the intervention and then obtain their opinion."[36]

29. Cf. above on implicit consent, and note 25.
30. Council of Europe, "Convention," art. 6.3.
31. Council of Europe, "Explanatory Report," nr. 43.
32. Council of Europe, "Convention," art. 6.1.
33. Ibid., art. 6.2 (minor) and 6.3 (adult).
34. Ibid., art. 6.2.
35. Ibid., art. 6.3.
36. Council of Europe, "Explanatory Report," nr. 46.

Moreover, the Convention pays attention to the patient's advance directives. It asserts that "previously expressed wishes related to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account."[37] This is the case with progressive diseases. According to the Explanatory Report taking the wishes into account "does not mean that they should necessarily be followed."[38] The reason may be that "the wishes were expressed a long time before the intervention and science has since progressed."[39]

Pastoral Counseling with Patients Not Able to Consent

The question arises whether surrogate consent is necessary for pastoral counseling with patients who are not able to consent. At first sight, it seems to be necessary. Pastoral counseling should be for the direct benefit of the patient and a representative should consent. However, is it reasonable to ask the representative's express consent when the patient's implicit consent would be sufficient, but is actually impossible? Or is it sufficient to take into consideration the wishes and opinion of the patient in proportion to age, degree of maturity, and degree of capacity to consent?

The answer is not easy. We give three considerations. First, it is unquestionable that the patient should be involved in giving consent as far as he or she is able to do so. This remains the best way to respect the wishes and the autonomy of the patient. A second consideration is that the representative should be asked for consent for a planned series of pastoral counseling. Unfortunately, this is rarely practicable for an unplanned or incidental pastoral encounter or conversation. A third consideration is that the patient's advance directives should be taken into account. Of course it is not necessarily the case that the patient has expressed advance directives concerning pastoral counseling. But, whatever the case should be, the pastor can assess whether pastoral counseling is in line with the fundamental choices the patient has made during his or her life. If there is a contra-indication, the pastor should withdraw from providing pastoral counseling.

Probably, the best answer to the problem of pastoral counseling with patients who are unable to consent is a combination of the three considerations: in so far as it is possible, the patient's current consent,

37. Council of Europe, "Convention," art. 9.

38. Council of Europe, "Explanatory Report," nr. 62.

39. Ibid.

the representative's consent as far as this is feasible, and the patient's advance directives in so far as these have been previously expressed. Nevertheless, we continue our exploration of the literature on pastoral ethics in order to find practical concepts of consent that are easily applicable to pastoral counseling.

Pastoral Ethics

The results of our exploration of literature on pastoral ethics and professional ethics for pastors have been disappointing: in professional ethics and professional codes for pastors, informed consent is not a topic of discussion.[40] Of course, respect is a key concept. But this does not imply the duty to ask for an informed consent. As far as we know, only two manuals bestow attention on the question.

In the manual *Christian Counseling Ethics*, Horace Lukens deals with the question of informed consent.[41] He spells out a number of specific items that the therapist should provide for the client as a part of informed consent: "information about the services provided," "goals of therapy and procedures to be used," "financial issues," "confidentiality," "qualifications," and "other pertinent information."[42] Furthermore, Thomas Rodgerson proposes similar items: "the nature and risks of therapy, the alternatives to treatment, the qualifications and values of the counselor, the nature or the fees and the policies regarding cancellations, the limits to confidentiality, ant the right to terminate."[43] The content as well as the terminology indicates clearly that both authors focus on (Christian) therapists and a planned series of sessions and not specifically on pastors.

More interesting is the chapter on "Permission for Mission" in the book *Gentle Shepherding: Pastoral Ethics and Leadership*, by Joseph Bush.[44]

40. For literature on professional ethics for pastors, cf. note 1. Among the most important codes for pastors, cf. American Association of Christian Counselors, "Code of Ethics"; American Association of Pastoral Counselors, "Code of Ethics"; Canadian Association for Spiritual Care, "Code of Ethics for Spiritual Care Professionals"; Netherlands Association of Spiritual Counsellors in Care Institutions, "Professional Standard Spiritual Counsellors."

41. Lukens, "Essential Elements for Ethical Counsel," 43–56.

42. Ibid., 50–51 passim.

43. Rodgerson, "Pastoral Counseling and the Informed Relationship," 398.

44. Bush, *Gentle Shepherding*, 44–69. Cf. Bush, "Informed Consent and Parish Clergy," 427–36.

He begins with a clear statement regarding pastors and informed consent. He asserts that "fortunately, unlike other types of health care professionals, pastors do not normally have to get written permission from each person in his or her congregation to exercise pastoral ministry to these individuals."[45] We should remark that Bush refers here to "clergy" working in a parish or congregation and not to pastors or chaplains in a hospital or care service. Nevertheless, his perspective is very interesting. In his opinion, informed consent can be established verbally rather than in writing. Moreover, he considers informed consent as an ongoing conversation of establishing informed consent.[46]

Establishing Informed Consent

According to Bush, informed consent in pastoral counseling occurs largely through the conversation between pastor and patient. It involves both parties and both should listen and speak with care. Careful listening by the pastor means that the pastor listens sensitively to the patient so as to hear his or her expectations and to clarify the nature of these expectations with the patient.[47] Careful speaking means that the pastor communicates honestly about the kind of pastoral counseling he or she can offer as an appropriate response to the expectations.[48] This implies that the pastor is fully aware of the limits of pastoral counseling. Therefore, the pastor makes clear that other kinds of care are available and is ready to refer the patient to another care provider.

Through this conversation, informed consent is established. A written consent is not necessary; a verbal consent is sufficient. Bush does not clearly affirm, but it seems that, in his opinion, the verbal consent is rather an implicit than an express consent. Establishing informed consent happens through the whole conversation. The pastor should be attentive that he or she receives and retains informed consent.

45. Ibid., 48.

46. Ibid., 187, n. 8. Bush refers to Welfel, *Ethics in Counseling and Psychotherapy*, 111–15.

47. Ibid., 63–64.

48. Ibid., 64–68.

Informed Consent as a Dialogical Process

In our view, we consider establishing informed consent as a "dialogical process."[49] Pastoral counseling is a process of dialogue between the pastor and the patient, through which informed consent is established. An important element of this dialogical process is providing and receiving information. The pastor informs the patient by introducing himself or herself as being pastor and, when appropriate, by explaining the purpose, possibilities, and limits of pastoral counseling. The patient, on his or her part and when suitable, informs the pastor about his or her own expectations. If necessary, the pastor might help to clarify the patient's expectations. In this way, the expectations and the possibilities can be fine-tuned through the dialogue. Together, pastor and patient inform each other through the process of pastoral counseling.

Based on this mutual information, another important element of the dialogical process is giving and receiving consent. The consent can be positive as well as negative, by means of an informed consent, or an "informed refusal." Through the dialogical process, the pastor should "create an opportunity" for the patient to consent to or to refuse pastoral counseling. The creation of that opportunity by the pastor is crucial. Moreover, the consent or refusal can take various forms, express or implicit, verbal or non-verbal. The pastor should be very attentive in order to detect both the verbal as well as the non-verbal signs of consent or refusal. Non-verbal signs of consent or refusal can be communicated through emotional expressions or body language.

Informed consent, in our view, may not be considered as a decision and authorization that is provided at a given moment. On the contrary, informed consent is an ongoing process through the dialogue and the counseling. During the whole process of counseling, pastor and patient inform each other concerning the possibilities and expectations. On the basis of this shared information, they continuously give shape to and participate in the process of pastoral counseling. Yet, it is the pastor's responsibility to be attentive to the patient's verbal and non-verbal signs of consent or refusal, and to respect them.

49. Cf. Liégeois, *Waarden in dialoog*, 59–61.

FURTHER THAN INFORMED CONSENT

Although informed consent is very important for pastoral counseling, in our opinion it is insufficient for guaranteeing an ethical way of dealing with asymmetry and power imbalance. Good reason is to be found for this at the core of Christian ethics. It brings to light that we should not only focus on the patient, but also on the pastor.

The Sources of Morality

In the tradition of Christian ethics, we find the theory of the so-called "three sources of morality."[50] As the name suggests, this theory postulates that there are just three sources of morality: the intention of the person acting, the object or the act-in-itself, and the circumstances surrounding the action. These three elements determine the "ethical" quality of the human action. The intention is the "internal part" of the human action; it is the "end" or the "purpose" of the action and gives "personal meaning" to the action. The act-in-itself is the "external part" of the human action; it is the "means-to-an-end" of the action and can be easily observed. Finally, there are the circumstances in which the action is realized and that include the consequences of the action.[51] The human action as a whole consists of the three elements: act, intention, and circumstances.

According to the theory of the three sources of morality, the ethical evaluation of the human action is also based on these three elements. The act cannot be evaluated without considering the intention of the person acting. Two similar acts may have a different moral quality depending on the intention of the person acting. Different intentions may confer different evaluations of human actions. Consequently, proportionality is necessary between the intention and the act. An act cannot represent any intention and, vice versa, an intention cannot be realized in whatever act. The end does not justify all means. Only an act congruent with or in proportion to the intention can adequately fulfill or express that intention.

50. For an explanation of the sources of morality, cf. *Catechism of the Catholic Church*, nr. 1749–1754; Gula, *Reason Informed by Faith*, 265–67; Janssens, "Ontic Evil and Moral Evil," 116–33. The three sources of morality are: the *finis operantis* (intention), the *finis operis* (object), and the *circumstantiae* (circumstances). The basis of these three sources of morality can be found in the description of the human act by Thomas Aquinas, *Summa Theologica*, IaIIae, q. 18, a. 2–4.

51. Gula, *Reason Informed by Faith*, 265.

The proportion is therefore the criterion for evaluating the ethical quality of the human action as a whole, considering the three sources: the act should be proportionate to the intention, taking the circumstances into account. Gula affirms in a clear way that "only by considering the action in reference to the intention within the total context of its qualifying circumstances, we can determine the true moral meaning of the action."[52] This ethical vision can be applied to the question of dealing with power in pastoral counseling.

The Proportionality of Pastoral Counseling

The three elements can be easily distinguished in pastoral counseling. The act is the process of pastoral counseling between pastor and patient. The circumstances are determined by the asymmetric relationship and the power imbalance between pastor and patient. The intention is twofold. Both the patient and the pastor have a certain intention in pastoral counseling.

Until now, we have focused on the patient's perspective. The intention of the patient is usually personal and determined by his or her expectations. From the patient's perspective, the act of pastoral counseling should be proportionate to his or her intention, taking into account the circumstances of the pastoral relationship. For the pastor, it is impossible to know how the patient evaluates the proportionality between his or her own intention and the counseling process in the given relationship. The only way to come to know the patient's evaluation is by asking his or her informed consent, presuming that the patient will only consent if there is proportionality.

Now it is time to move on to the pastor's intention and the proportionality between the pastor's intention and the process of pastoral counseling in the context of the asymmetric relationship. What is the intention of the pastor? Is the act of counseling, in the given context of the relationship, a proportionate expression or fulfillment of the purpose of pastoral counseling?

The Complexity of the Intention

An intention is an end, a purpose that a person is seeking to achieve. We have already touched on the purpose of the pastoral counseling in our

52. Ibid., 267.

earlier description and definition: it is the empowerment by the pastor of the patient in his or her own quest for meaning and/or faith in life.[53] In other words, the purpose of pastoral counseling is to encourage and strengthen the patient so that he or she is able to understand meaning and/or faith in life more clearly and to experience them more deeply. The intention of the pastor is justified to the extent to which it aims at this purpose.

A particular problem in this respect is the fact that human intentions are seldom unambiguous. Our actions are hardly ever motivated by one single intention. On the contrary, psychology has demonstrated that the motivation of human behavior is multi-causal and can be influenced by many different factors. In particular, transference and counter-transference in the relationship between pastor and patient can play a crucial role.[54] Through the process of transference, the patient projects onto the pastor a number of unfulfilled wishes or unresolved problems stemming from relationships with other important people in his or her life. Through the process of counter-transference, the pastor projects a number of his or her own unfulfilled wishes and unresolved problems back onto the patient.

As a result, a pastor might sometimes attempt to enter into a relationship with a patient in order to help that person. But in fact, through that relationship, the pastor is seeking to satisfy his or her own desires for contact or to find solutions to his or her emotional problems. This distorts the professional relationship that has as its purpose the empowerment of the patient and may lead to unjustifiable or inappropriate behavior. Alternatively, a pastor may genuinely believe that asking the patient for certain information is justified in terms of achieving the purpose of the pastoral counseling. But in fact, the pastor is interested in that information because it refers to similar facts or events in his or her own life, or because the pastor has become curious about the life story of the patient, or because the pastor recognizes a person he or she is acquainted with in the patient's environment. The pastor then becomes intrusive in the patient's private life and betrays the trust the patient has given. Therefore, the pastor needs to learn how to deal with his or her own desires and problems in the pastoral relationship.

53. Cf. above on empowerment, and note 10.

54. Hartung, "Transference," 1285–86.

Moral Integrity

As a consequence, we can reasonably expect a pastor to behave with integrity.[55] This ethical virtue comprises two elements. First, integrity is the ability and the quality of acting in such a way that there is a correspondence between the intention and the act. This entails a correlation between what the pastor feels and thinks on the one hand, and what he or she says and does on the other hand. The pastor must only do things and say things that agree with his or her own feelings and opinions. Secondly, integrity is the ability and the quality of acting in accordance with values and norms. It implies that there is no discrepancy between what the pastor postulates in ethical terms and what he or she actually does. If the pastor possesses integrity, he or she will be regarded as being trustworthy, honest, and reliable.

Integrity is important for all human beings, but for the pastor the question of integrity goes much deeper. By virtue of the pastor's ecclesiastical, professional, and personal character, the pastor refers to and witnesses to the higher reality of the sacred or to a personal God. This implies that a pastoral relationship creates a kind of spiritual sanctuary, an open space in people's hearts and minds that encourages trust and surrender to God. This sacred or divine space must be protected at all costs and must not be desecrated by inappropriate pastoral counseling on the part of the pastor.

Emotional Integrity

Moral integrity presupposes that the pastor has already attained a high level of emotional integrity. First, the pastor should possess a high degree of self-knowledge. This is necessary in order to be aware of his or her desires and needs and the role that these can play in the processes of transference and counter-transference. Moreover, good self-knowledge also makes it easier to recognize when certain dominant emotions run the risk of leading to inappropriate behavior.

This brings us to the pastor's self-care. One of the pastor's tasks is to ensure his or her own physical, emotional, social, and spiritual well-being. Being comfortable and content with the experience of one's own private and professional life is an important precondition for keeping one's feelings and needs detached from one's professional relationships. If the pastor is not able to do this, he or she may need external support and guidance.

55. Musschenga, *Integriteit*, 167–93.

This support can be provided in a general way through formation and training in dealing with power imbalances and informed consent. But often, a more personal guidance is needed. The pastor can seek this help from a colleague or a friend, or by making use of the existing supervision and intervision procedures, or, when necessary, by undergoing psychotherapy. The advice of an external person might help the pastor to clarify his or her own desires and needs, permitting the person to function more effectively at both a personal and a professional level.

CONCLUSION

In this paper we have discussed the meaning of informed consent in pastoral counseling. We conclude with ten statements.

1. The asymmetry or unequal position of pastor and patient in the pastoral relationship creates an imbalance of power. This unequal position is due to the ecclesiastical, professional, and personal character of the pastor's identity and the vulnerable and dependent position of the patient.
2. The unequal position and power imbalance are structural facts. From an ethical point of view, they can be considered as "premoral" evils. They become "moral" goods or evils depending on the way the pastor deals with them. This implies that the pastor may not harm the patient, but should empower the patient.
3. We define pastoral counseling as an empowering companionship between a pastor and a patient. Empowerment expresses the purpose of pastoral counseling: the pastor strengthens the patient in his or her own quest for meaning and/or faith in life. In order to empower the patient, the pastor should request the informed consent of the patient.
4. Medical ethics describes informed consent as the voluntary decision and authorization given by the competent patient in favor of a certain intervention, based on the understanding of the information on and recommendation of that intervention. This concept can only be applied in the case of planned sessions of pastoral counseling.
5. Patient's rights make clear that various forms of informed consent can be used in pastoral counseling. Express consent, either written or verbal, is not always achievable. Implicit consent can be appropriate, as

long as the patient is sufficiently informed. This implicit consent can be applied to unplanned or incidental pastoral counseling.

6. Some patients are not able to consent. Nevertheless, the pastor can involve the patient in giving consent as far as he or she is able to do so. For planned sessions of pastoral counseling, the pastor can ask a surrogate informed consent from a representative. The pastor can also search for advance directives concerning pastoral counseling or assess whether pastoral counseling is in line with the patient's fundamental options.
7. Pastoral ethics demonstrate that establishing informed consent is a "dialogical process" of mutual listening and speaking. The pastor gives information regarding the possibilities and the limits of pastoral counseling, and the patient regarding his or her expectations. The pastor creates opportunities in which the patient can consent or refuse in an express or implicit, verbal or non-verbal way. Informed consent is an ongoing process.
8. The sources of morality make clear that for the evaluation of a human action, the act should be proportionate to the intention, taking the circumstances into account. The proportionality of pastoral counseling depends on the patient's informed consent and on the pastor's intention.
9. The intention of the pastor should be the empowerment of the patient. But human intentions are multi-causal and influenced by transference and counter-transference. Therefore, the pastor should learn how to deal with his or her own desires and problems in the pastoral relationship.
10. Moral integrity is an important virtue for the pastor. It is the ability and quality of acting in correspondence with his or her intention and with values and norms. Moral integrity presupposes emotional integrity. Therefore, the pastor needs self-knowledge, self-care, and when necessary, external support.

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